PUBLIC REPORT OF THE MARKET CONDUCT EXAMINATION

OF THE CLAIMS PRACTICES OF THE

UNUM LIFE INSURANCE COMPANY OF AMERICA
NAIC # 62235 CDI # 2039-6

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY
NAIC # 68195 CDI # 0950-6

PAUL REVERE LIFE INSURANCE COMPANY (THE)
NAIC# 67598 CDI# 1083-5

AS OF JUNE 30, 2003

STATE OF CALIFORNIA

DEPARTMENT OF INSURANCE

MARKET CONDUCT DIVISION

FIELD CLAIMS BUREAU

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DEPARTMENT OF INSURANCE
Consumer Services and Market Conduct Branch
Field Claims Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013

September 23, 2005

The Honorable John Garamendi
Insurance Commissioner
State of California
45 Fremont Street
San Francisco, California 94105

Honorable Commissioner:

Pursuant to instructions, and under the authority granted under Part 2, Chapter 1, Article 4, Sections 730, 733, 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, an examination was made of the claims practices and procedures in California of:

Unum Life Insurance Company of America

NAIC # 62235

Provident Life and Accident Insurance Company

NAIC # 68195

Paul Revere Life Insurance Company (The)

NAIC# 67598

Hereinafter also referred to as Unum Life, Provident Life, Paul Revere Life or collectively as the Companies.

This report is made available for public inspection and is published on the California Department of Insurance web site (www.insurance.ca.gov) pursuant to California Insurance Code section 12938.

SCOPE OF THE EXAMINATION

This report documents the results of two separate file review processes. The initial, routine examination covered the claims handling practices of the aforementioned Companies during the period February 1, 2001 through January 31, 2002. A targeted review of Long Term Disability claim files was later added with a window period of January 1, 2000 through June 30, 2003. The combined examination was made to discover, in general, if the claims handling practices and other operating procedures of the Companies conform with the contractual obligations in the policy forms, to provisions of the California Insurance Code (CIC), the California Code of Regulations (CCR), the California Vehicle Code (CVC) and case law. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. Alleged violations of other laws are placed in a separate report which remains confidential subject to CIC Section 735.5.

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Companies for use in California including any documentation maintained by the Companies in support of positions or interpretations of fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of claims files and related records.

3. A review of consumer complaints received by the California Department of Insurance (CDI) in the most recent year prior to the start of the examination.

The examination was conducted in the Glendale, California office of Unum Life Insurance Company of America.

The report is written in a "report by exception" format. The report does not present a comprehensive overview of the subject insurer's practices. The report contains only a summary of pertinent information about the lines of business examined and details of the non-compliant or problematic activities or results that were discovered during the course of the examination along with the insurer's proposals for correcting the deficiencies. When a violation is discovered that results in an underpayment to the claimant, the insurer corrects the underpayment and the additional amount paid is identified as a recovery in this report. All unacceptable or non-compliant activities may not have been discovered, however, and

failure to identify, comment on or criticize activities does not constitute acceptance of such activities.

Any alleged violations identified in this report and any criticisms of practices have not undergone a formal administrative or judicial process.

CLAIM SAMPLE REVIEWED AND OVERVIEW OF FINDINGS

The examiners initially reviewed files drawn from the category of Closed Claims for the period February 1, 2001 through January 31, 2002, commonly referred to as the "review period". The examiners reviewed 353 Unum Life Insurance Company of America claim files, 268 Provident Life and Accident Insurance Company claim files and 156 Paul Revere Life Insurance Company claim files. The examiners cited 243 claims handling violations of the Fair Claims Settlement Practices Regulations and/or California Insurance Code Section 790.03 within the scope of this report. The targeted review involved claims drawn from a run of Closed Claims for the period January 1, 2000 through June 30, 2003. In addition, the review included files relating to Independent Medical Examinations (IME's) and Rehabilitation Assessments. The examiners reviewed 156 Unum Life, 85 Provident Life and 29 Paul Revere Life Long Term Disability claim files. As a result of the targeted review, the examiners cited 58 claims handling violations of the Fair Claims Settlement Practices Regulations and/or California Insurance Code Section 790.03 within the scope of this report.

Further details with respect to the files reviewed and alleged violations are provided in the following tables and summaries.

Unum Life Insurance Company of America (initial review)			
CATEGORY	**CLAIMS FOR REVIEW PERIOD**	**REVIEWED**	**CITATIONS**
Group Long Term Disability (LTD)	4131	93	32
Individual Disability	360	71	16
Group Life	1082	19	8
Individual Life	65	37	32
Group Life AD & D	50	49	8
Special Risk AD & D	147	30	7
Long Term care	121	54	4
TOTALS	5956	353	107

Provident Life and Accident Insurance Company (initial review)			
CATEGORY	**CLAIMS FOR REVIEW PERIOD**	**REVIEWED**	**CITATIONS**
Group Long Term Disability (LTD)	241	78	16
Individual Disability	1201	53	2
Group Life	721	83	50
Individual Life	64	37	23
Group Life AD & D	32	17	8
TOTALS	2259	268	99

Paul Revere Life Insurance Company (The) (initial review)			
CATEGORY	**CLAIMS FOR REVIEW PERIOD**	**REVIEWED**	**CITATIONS**
Group Long Term Disability (LTD)	239	49	14
Individual Disability	609	82	12
Individual Life	38	25	11
TOTALS	886	156	37

Unum Life Insurance Company of America (targeted review)			
CATEGORY	**CLAIMS FOR REVIEW PERIOD**	**REVIEWED**	**CITATIONS**
Group Long Term Disability	12646*	137	27
Individual Long Term Disability	931*	19	6
TOTALS	13577*	156	33

Provident Life and Accident insurance Company (targeted review)			
CATEGORY	**CLAIMS FOR REVIEW PERIOD**	**REVIEWED**	**CITATIONS**
Individual Long Term Disability	2181*	80	18
Group Long Term Disability	258*	5	3
TOTALS	2439*	85	21

Paul Revere Life Insurance Company (The) (targeted review)			
CATEGORY	**CLAIMS FOR REVIEW PERIOD**	**REVIEWED**	**CITATIONS**
Individual Long Term Disability	1163*	21	4
Group Long Term Disability	241*	8	0
TOTALS	1404*	29	4

* These numbers represent claim files. Some claimants had multiple individual disability claims and/or an individual and group claims. Each claimant was considered as a single claim file

irrespective of the number of claims the individual had in the file. In addition, many of the claims for the review period appeared on more than one list as various areas of concern were identified and additional list of claim were requested. A list of claims that had IME's was also requested (The IME listing was not separated by Company. The IME list of claims was 803 claim files inclusive of all three Companies.) It was also noted that some of the claims provided for review were not claims involving California insurance contracts. These claims were eliminated from the review.

TABLE OF TOTAL CITATIONS (initial review)				
Citation	**Description**	**Unum Life Insurance Company of America**	**Provident Life and Accident Insurance Company**	**Paul Revere Life Insurance Company (The)**
CCR§ 2695.11(b)	The Company failed to provide a clear explanation of the computation of benefits.	41	76	14
CCR§ 2695.7(b)(3)	The Company failed to include a statement in their claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance.	18	2	6
CIC§ 790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.	12	4	1
CIC§ 790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverage at issue.	5	4	3
CCR§ 2695.7(g)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low.	6	2	2
CCR§ 2695.4(a)	The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.	6	5	0
CIC§ 790.03(h)(5)	The Company did not attempt in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability becomes reasonably clear.	6	1	1
CCR§ 2695.7(f)	The Company failed to provide written notice of any statute of limitation or other time period requirement not less than sixty days prior to the expiration date.	3	1	4
CCR§ 2695.4(d)	The Company improperly required a claimant to give notification of a claim or proof of claim within a specified time.	4	1	0
CCR§ 2695.5(b)	The Company failed to respond to communications within fifteen calendar days.	2	1	1
CCR§ 2695.5(e)(1)	The Company failed to acknowledge notice of claim within fifteen calendar days.	2	1	1
CCR§ 2695.7(d)	The Company persisted in seeking information not reasonably required for or material to the resolution of a claim dispute.	1	0	1
CCR§ 2695.5(e)(3)	The Company failed to begin investigation of the claim within fifteen calendar days.	1	0	1
CCR§ 2695.6(a)	The Company failed to adopt and communicate to all its claims agents written standards for the prompt investigation and processing of claims.	0	1`	0
CCR§ 2695 .3(b)(2)	The Company failed to record in the file the date the Company received, date the Company processed and date the Company transmitted or mailed every relevant document in the file.	0	0	1
CCR§ 2695.7(b)(1)	The Company failed to provide written basis for the denial of the claim.	0	0	1
Total Citations		107	99	37

TABLE OF TOTAL CITATIONS (targeted review)				
Citation	**Description**	**Unum Life Insurance Company of America**	**Provident Life and Accident Insurance Company**	**Paul Revere Life Insurance Company (The)**
CIC § 790.03(h)(5)	The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability had become reasonably clear.	24	13	2
CIC § 790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverage at issue.	6	3	1
CCR § 2695.3(a)	The Company's claim file failed to contain all documents, notes and work papers which pertain to the claim.	3	5	1
Total Citations		33	21	4

SUMMARY OF CRITICISMS, INSURER COMPLIANCE ACTIONS AND TOTAL RECOVERIES

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. Regardless of the remedial actions taken or proposed by the Companies, it is the Companies' obligation to ensure that compliance is achieved. The total money recovered within the scope of this report during the examination process was $51,552.96. Additional details regarding the resolution of these criticisms may be found in the settlement documents that resulted from this examination. Unless otherwise noted, all changes in procedures are being implemented by October 3, 2005. Unless otherwise noted, all policy language changes are being implemented by November 1, 2005.

A. SUMMARY OF FINDINGS FROM THE INITIAL REVIEW SAMPLE:

1. The Companies failed to provide an explanation of the computation of benefits. In 131 instances, the Companies failed to provide each claimant with a clear explanation of the computation of benefits. On life insurance claim settlements involving payment of interest, the company did not identify the rate of interest and the period of time to which the interest had been applied. The Companies also did not identify the amount to which the interest was applied. The explanation supplied did not include an actual computation of the settlement amount.

Further, the settlements often included multiple components that were not identified, such as the base policy benefit, amount of returned premium, amount of paid up additions, amount of insurance reflected by a percentage of wage, amount of additional coverage elected by the insured, cost of living adjustments, seat belt benefits, etc. The Companies simply provided a dollar amount of settlement. The consumer could not determine if the computation was correct without this information. (As evidence of the impact of these alleged violations, four claims cited for low settlement were a result of the Companies' failure to pay for a seatbelt life benefit. Without an explanation of this component of the life settlement, beneficiaries are unable to read the policy provisions and determine if they received the proper settlement.) The Department alleges these acts are in violation of CCR §2695.11(b).

Summary of Companies' Response: The Companies acknowledge that payments did not include the rate of interest in the explanation of benefits. While the Companies believe that this is not required, they have taken steps to utilize standard letters that will include the rate of interest and the component parts of the computation of benefits. The Companies are also implementing a procedure to notify life insurance beneficiaries once a claim is presented of any additional benefits that may be payable under the policy. This notice is separate from the communication made at the time that benefits are paid and contains a cover letter and copies of applicable policy specifications.

2. The Companies failed to include a statement in their claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance. In 26 instances, the Companies failed to include a statement in their denial that, if the claimant believes the claim has

been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance. This includes initial claim denials and second denial of claims appealed under the Employee Retirement Income Security Act (ERISA) appeal. On claims where the claimant had submitted substantial new proof of claim during the appeals process, the Companies did not include the CDI language when upholding the original denial. This in effect limits the CDI language to one denial letter per claim and all subsequent denials are referred to as upholding the appeal. The Companies are also not including the CDI language on claims where the beneficiary lives out of state. Even though the life claim involves a California contract and a California resident who dies in California, the Companies maintain that the California Statutes do not apply to beneficiaries living out of state. Denial letters sent to claimants/beneficiaries living out of state did not include the CDI language. The Department alleges these acts are in violation of CCR §2695.7(b)(3).

Summary of Companies' Response: The Companies acknowledge this finding and state it is their standard procedure to include such language in all claim denials in which the beneficiary is a California resident. The Companies' claim staff has been counseled to ensure future compliance.

The Companies will now include the notification in claims involving an ERISA appeal (e.g., when a claimant submits additional information for the Companies to review and the Companies uphold the initial denial), although the Companies do not believe this notification is required on the grounds that this subsequent letter is not a denial, but an informative letter advising the Companies are upholding the initial denial.

Further, the Companies will include the CDI language in denial letters to claimants who are not California residents, but who present claims under California-sitused policies or policies in which the policyholder or beneficiary is a California resident. This notice will be provided, as will other states' contact information, as may be applicable.

3. The Companies failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies. In 17 instances, the Companies failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies. This problem was identified primarily in the Long-Term Disability files reviewed. Once the Companies had information that indicated the claimant was no longer disabled, or determined that the information they did have was not sufficient proof of disability, the Companies stopped performing their investigation of the claim. The Companies' medical consultants often identified the need to obtain specific medical records and specific clarifications from the claimant's doctors regarding medical restrictions and limitations. Such information might have lead to a conclusion that the claimant was indeed disabled. The Companies had authorization but did not request the records and/or did not put forth the specific questions directly to the physician. Instead, the Companies would simply inform the insured that the monthly disability statement signed by the insured doctor did not supply enough clarification to continue benefits. The burden of obtaining the very detailed and specific information needed to continue benefits was placed upon the claimant. These allegations also include instances of the Companies' failure to investigate statements from attending physicians reflecting additional periods of disability. The Department alleges these acts are in violation of CIC § 790.03(h)(3).

Summary of Companies' Response: The Companies have refined their guidelines regarding investigation of a claim, which now require that once a claimant has submitted a proof

of loss, the Companies will make every reasonable attempt to obtain medical information necessary in order to adjudicate the claim. The Companies will also attempt to obtain, at the Companies' expense, information that is necessary for the prompt resolution of the claim.

Under the Companies' new claims process, the Quality Compliance Consultant will be available to review files before a non-compensable claim decision is made in order to ensure that the Companies' protocols have been adhered to and that communications to claimants are appropriate.

4. The Companies misrepresented to claimants pertinent facts or insurance policy provisions relating to coverage at issue. In 12 instances, the Companies misrepresented pertinent facts or insurance policy provisions to claimants relating to coverage at issue.

The examiners noted letters and information packets sent to the insured that included statements indicating that the policy requires the claimant to apply for Social Security Disability Income benefits or the claimant "must" apply for Social Security Disability Income benefits. Although the policy provisions include an offset for Social Security benefits received, it is not stated as a policy requirement that the claimant must apply for Social Security Disability Income benefits. The correspondence misrepresents the insurance policy provisions. The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of Companies' Response: The Companies disagree that they misrepresent pertinent facts or insurance policy provisions relating to coverage. The Companies acknowledge that the policy does not include the statements that the claimant "must" or is "required" to apply for Social Security Disability Income (SSDI) Benefits, but believe that the language states an application is required to obtain an unreduced benefit. The Companies have revised their letters to the claimants by removing anything that would lead a policyholder to infer that the policy "requires" him or her to file for SSDI benefits in order to receive policy benefits. The Companies will only offset benefit payments against amounts the claimant has actually received in awards of SSDI benefits.

5. The Companies attempted to settle a claim by making a settlement offer that was unreasonably low. In 10 instances, the Companies attempted to settle a claim by making a settlement offer that was unreasonably low. These instances involved failure to identify policy provisions and provide payment reflecting the available coverage. This included policy provisions for waiver of premium, cost of living endorsements and four claims involving seat belt benefits on loss of life claims. Also included were a miscalculation of benefits, failure to send the settlement check and failure to make additional payment per endorsement. The Department alleges these acts are in violation of CCR §2695.7(g).

Summary of Companies' Response: The Companies acknowledge the above instances of failure to pay all coverage triggered by the claim and have made any necessary supplemental payments. However, the Companies maintain these underpayments were oversights by their claims handlers and no corrective action is warranted. With respect to additional coverages (e.g., seatbelt coverages), the Companies have implemented further claims processes for California policies to enhance the communication of coverages related to life insurance and accidental death and dismemberment claims. The Companies will implement a procedure to send the claimant a cover letter explaining that additional benefits may be

available, and a copy of the policy specifications relating to the additional benefits potentially available under the policy at issue.

6. The Companies failed to disclose all benefits, coverages, time limit or other provisions of the insurance policy that may apply to the claim presented by the claimant.

In 11 instances, the Companies failed to disclose all benefits, coverages, time limits or other provisions of the insurance policy that may apply to the claim presented by the claimant. These activities included charging claimants who wanted to verify coverage and applicable benefits a $25 administrative fee before providing a copy of the individual life policy and the failure to explain or document disclosure of policy provisions of the group life policies including seat belt benefits and college tuition benefits for children of the deceased who were attending college**.** (As mentioned earlier, the examiners identified four death claims involving car accidents in which the insured was wearing a seat belt and was entitled to an additional death benefit that was not explained or paid**.**) In addition, the Companies denied survivor benefits on Group Long-Term Disability claims when an estate had not yet been formed. The Companies did not inform the potential beneficiaries of the amount of benefits available should an estate be formed. The Department alleges these acts are in violation of CCR §2695.4(a).

Summary of Companies' Response: Copies of individual policies are provided to insureds at policy inception, and again upon filing of a claim, at no charge. This procedure will be reiterated to staff. The Companies maintain that they are not aware of any regulation that requires them to explain coverage prior to payment of the claim. The companies indicate that while CCR §2695.4(a) states that the insurer shall disclose benefits that may apply to the claim presented, the Companies' position is that only coverage provisions that do apply to the claim are required by CCR §2695.4(a) to be disclosed and that these coverages are explained at the time of payment. However, the Companies are implementing new claims processes to enhance communication about all applicable coverages earlier in the claims process.

With respect to additional coverages (e.g., seatbelt coverages), the Companies have implemented further claims processes for California policies to enhance the communication of coverages related to life insurance and accidental death and dismemberment claims. The Companies now send the claimant a cover letter explaining that additional benefits may be available, and a copy of the policy specifications relating to the additional benefits potentially available under the policy at issue.

The Companies are enhancing their communications relating to eligible survivors and clarifying that when no eligible survivors and no estate exist, that benefits are payable once an estate is formed.

7. The Companies did not attempt in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability becomes reasonably clear. In eight instances, the Companies did not attempt in good faith to effectuate prompt, fair, and equitable settlement of claims in which liability becomes reasonably clear. Four of the claims involve the Companies' failure to pay survivor benefits on Group Long-Term Disability claims. The Companies contend that their policy language regarding survivor benefits authorizes them to not pay survivor benefits if no one meets the definition of eligible survivor and no estate is formed The policy language does not conform to mandatory statutory language. Additional violations included: denial of claim for a pre-existing condition when the condition was not actually diagnosed in the period of time allowed by policy conditions; identifying an underpayment and waiting an additional nine months before paying the underpaid amount; denying a claim based

on the insurer's definition of the claimant's occupation and not based upon the work that was actually being performed by the claimant; and, denial of accidental death benefits involving a slip and fall. The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of Companies' Response: The Companies maintain that the four claims where survivor benefits were not paid were handled in accordance with policy provisions. The policy provisions define "eligible survivor" as a spouse, if living, otherwise, children under the age of 25. If there are no eligible survivors, payment will be made to the estate. The Companies maintain that in these four instances there was no eligible survivor and no estate, thus payments were made in accordance with policy provisions. The Companies are reinforcing and formalizing a procedure to inform survivors who may be known to the Companies (and who are not eligible survivors under the terms of the contract) of what is necessary in order to make benefits payable under the policy. The Companies will also eliminate the age limitations for surviving children in the definition of "eligible survivor". If there is no eligible survivor or estate and the policy is subject to California jurisdiction, survivor benefits will be escheated to the state pursuant to California law.

8. The Companies failed to provide written notice of any statute of limitation or other time period requirement not less than sixty days prior to the expiration date. In eight instances, the Companies failed to provide written notice of any statute of limitation or other time period requirement not less than sixty days prior to the expiration date. The Department alleges these acts are in violation of CCR §2695.7(f).

Summary of Companies' Response: The Companies acknowledge that the statute of limitations language was inadvertently not included in denial letters in the above instances. The Companies state that this is a problem specific to one claims handling location. The location was not utilizing standard template language that does include the statute of limitations notice. The Companies have rectified this problem with the implementation of a standard letter library and a communication to the adjusters to use only those templates within the standard letter library. The statute language notice is also covered in the Companies' claims manual.

9. The Companies improperly required a claimant to give notification of a claim or proof of claim within a specified time. In five instances, the Companies sent letters to claimants requesting proof within a specified time not supported by policy provisions or statute. Specifically, the Companies sent out letters indicating the claimant has 21 days from the date of the letter to provide proof of claim or the Companies would have no alternative other than to suspend benefits or close the claim. The Department alleges these acts are in violation of CCR §2695.4(d).

Summary of Companies' Response: The Companies explained that where a claimant had failed to respond to a request for proof of continuing disability within the 30 days required under the policy, they had a practice of granting claimants an additional 21 days beyond the time limit contained in the policy to comply with the request. While not agreeing that this practice was non-compliant, the Company now agrees to provide claimants with an additional 30 days (instead of 21 days) after the initial 30-day period has passed in order to reduce confusion regarding these time limitations. The Companies have conducted training to ensure that time limitations communicated to insureds are in accordance with the policy and applicable law.

10. The Companies failed to comply with the Fair Claims Settlement Practices Regulations. In four instances each, the Companies failed to comply with the following Fair Claims Regulations: CCR § 2695.5(b) and CCR § 2695.5(e)(1). In two instances each, the Companies failed to comply with the following Fair Claims Regulations: CCR § 2695.7(d) and CCR § 2695.5(e)(3). In one instance each, the Companies failed to comply with the following Fair Claims Regulations: CCR § 2695.6(a), 2695.3(b)(2) and 2695.7(b)(1).

Summary of Companies' Response: The Companies acknowledge the above findings. The Companies indicate that, it is their standard procedure to comply with the Fair Claims Settlement Practices Regulations and that the above are isolated instances of non-compliance. The Companies have reinforced procedures with their claims handling staff to ensure future compliance with the Regulations.

B. SUMMARY OF FINDINGS FROM THE TARGET REVIEW SAMPLE:

1. The Companies failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. In 39 instances, the Companies failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The 39 alleged violations are a result of several practices that were identified as noncompliant. The Department alleges these acts are in violation of CIC §790.03(h)(5).
These include the following practices:

a. Nursing occupations

The Companies used an artificial definition of nursing occupations (State Licensure) to reflect a sedentary guidepost for all nurses. In other words, emergency room nurses, cardiac care nurses, clinical rehabilitation nurses, and newborn/infant care nurses, despite the very physical nature of the tasks they perform, were all combined into a single occupational definition that considered nursing a sedentary desk job. Thus staff nurses in any of the specialties identified above who could perform a desk job were determined not to be disabled from their own occupation. The examiners reviewed four claims involving non-sedentary nursing occupations in the "Own Occupation" period. All four had the same sedentary guidepost applied.

Summary of Companies' Response: The Companies agree to evaluate nursing occupations by reviewing the actual duties performed by the claimant prior to disability, and then determine based upon those duties what nursing occupation the claimant was performing. This methodology takes into account the physical component and specialized aspects of certain nursing occupations. The Companies have conducted additional training for claims processing personnel regarding nursing occupations and the distinctions among types of nursing duties. This training occurred in August, 2003, and is now a part of the standard training modules within the organization.

b. Medical specialties

The Companies sold coverage for disabilities relating to medical specialties but failed to provide coverage when the claimants could no longer perform their medical specialty. The Companies accomplished this by performing a review of the claimant's medical billing records. If, for example, the billing records indicated that the majority of time spent by a surgeon was in

consultations, case preparation or follow up check-ups rather than in actual surgery, then the surgeon was not considered disabled if he/she could no longer perform surgery. (No matter that the consultation, review, or follow-up work would not have been generated if the surgeon was not performing the relevant surgery.) Thus, clearly non-sedentary surgeons and obstetricians who could perform a desk job were determined not to be disabled from their own occupation. The examiners reviewed two claims involving medical billing assessments.

Summary of Companies' Response: The Companies use a review of medical billing records as one of many tools to ascertain the nature of a medical practice and the actual duties the claimant was engaged in prior to disability. The Companies agree to conduct additional training for claims processing personnel regarding the relationship between a non-sedentary component of a practice or another specialty and the ability to maintain a practice consisting of solely the sedentary aspects of that practice. New guidelines will also be developed to assist in the general determination of the ability of the claimant to maintain the specific practice in question.

c. Other "own occupation" coverage

The Companies denied benefits for claimants who had coverage for disabilities relating to their own occupation. Even though the files reflected the claimant could not perform their duties in the usual and customary way, the Companies determined the claimants could perform their occupations in a different setting. This included a warehouse worker who could no longer use his back, a professional whose job required travel who could no longer travel, a collection manager who could not handle the stress of collections, a software developer who could keyboard only one hour per day, etc. The Companies determined that, although these individuals might not be able to perform the tasks of their specific jobs, they could perform the tasks generally attributed to their general occupations. The guidepost utilized was "the occupation as it exists in the national economy". The use of these guideposts effectively resulted in the handling of claims under an "Own Occupation" coverage as if they were covered under "Any Occupation" coverage. The examiners reviewed six claims that were denied using the national economy methodology.

Summary of Companies' Response: The Companies' internal efforts are still underway to implement changes to its procedures for evaluation of total disability in light of the *Hangarter* decision (373 F. 3d 998 (9th Cir. 2004)). These changes include enhancement of existing occupational evaluation by applying the "usual and customary" and "reasonable continuity" guideposts under "own occupation" after the date of the *Hangarter* decision.

The Companies will also discontinue application of a "national economy" guidepost for Long Term Disability claim determinations under "own occupation" coverage.

d. Internal medical opinions

The examiners identified files wherein the Companies were not following the advice of their own medical consultants. These claims involved medical consultants paid by the insurer to review the medical records in the file. In some cases the medical consultants indicated disabling conditions but the Companies denied the claims. In some cases the medical consultants indicated the need for specific objective testing to determine the claimant's restrictions and limitations but the tests were not performed prior to discontinuing benefits. Seven claims were identified where the Companies ignored the advice of their own medical consultants or physicians paid to perform Independent Medical Examinations.

Summary of Companies' Response: The Companies have increased the documentation required in the claims processes generally, and particularly in the event of a claim denial. If the Companies' internal medical resources form an opinion based on the evidence in the record that is different from that offered by the attending physician or another independent medical review, the Companies' claim handling standards will require that the documentation cite to the clinical findings in the file upon which that opinion is based with specific and legitimate reasons to support the determination and an explanation as to why the attending physician's position is incongruous with the facts of the case.

The Companies have also developed enhanced protocols for requiring an Independent Medical Examinations in certain cases where the opinions of the equally credentialed in-house medical resource and the treating physician differ.

e. Policy Interpretation Issues

(1) "Self-reporting" claims

In 1995 Unum Life, incorporated language into group disability policies limiting the duration of "self-reporting" claims. The Unum Provident companies had adopted the position that only objective test results can substantiate disability as opposed to the claimant "self-reporting" disabling conditions. Claims that had multiple Independent Medical Examinations or Vocational assessments indicating claimants were disabled were denied additional benefits when the Company determined that the results of its own investigations were based on the "self-report" of the claimant and thus were not valid. We reviewed two claims where the concept of self-report was used to discount objective medical evidence in the file.

Summary of Companies' Response: The Companies disagree that they misused the limitation for self-reported conditions contained in certain of their policy forms. In 2002, enhanced training for claims staff was created in order to reinforce appropriate review of subjective conditions and the Companies augmented the criteria to be used in evaluating subjective complaints. The Companies will eliminate the self reporting limitation from policies offered or issued after the date of resolution of this examination.

(2) Mental Illness

The Companies misused policy language that imposes a 24-month limitation on claims involving mental illness. The 24-month limitation was applied to claims that had been paid for twenty-four months for physiological disabilities. An example is a claimant with an abnormal

heartbeat identified in a clinical setting who had not been treated for a mental illness for twenty-four months. The Company allocated benefits to reflect a mental illness and applied the 24-month limitation. The Company did not investigate whether the mental illness was related to the physiological disease process. The examiners identified three claims that involved the mental illness limitation on claims involving physiological diseases.

Summary of Companies' Response: The Companies disagree that they misuse policy language relating to mental illness limitations. However, the Companies will reinforce their training for claims processing personnel relating to evaluation of claims where mental and nervous conditions are at issue, particularly where other conditions also exist. This training will reiterate the application of *Patterson v. Hughes Aircraft Co.,* 11 F.3d 948 (9th Cir. 1993).

The Companies are increasing communication to claimants regarding applicability of mental and nervous limitations when a claim first is determined to be compensable. The Companies have agreed to amend policy language so that the limitation on a disabling mental or nervous condition does not run concurrently with the time limitation for a disabling physiological condition.

(3) Mandatory rehabilitation

The Companies misused the mandatory rehabilitation policy provision in the case of a claim that was denied based on the claimant's refusal to participate in a rehabilitation program that did not include any physical or mental rehabilitation. The examiners identified one claim involving a denial due to the mandatory rehabilitation clause.

Summary of Companies' Response: The Companies disagree that they misuse the mandatory rehabilitation provisions that are contained in certain of the Companies' policy forms. Pursuant to the policy provisions, this rehabilitation can include occupational and vocational rehabilitation.

However, the Companies now treat the rehabilitation provisions of the contracts that contain them as voluntary. Accordingly, the Companies do not deny or terminate claims for failure to participate in mandatory rehabilitation.

(4) Pre-existing condition

The Companies misused the policy language involved the "pre-existing" clause in the case of a claimant who was overweight. The Companies determined that obesity can contribute to disorders of the "musculoskeletal, cardiovascular, peripheral vascular and pulmonary systems." The claimant, who had no previous treatment for orthopedic problems, had her claim denied based on the Companies' characterization of her weight as a pre-existing condition that had contributed to the disabling condition. The examiners identified two files involving denials based on the misuse of pre-existing conditions.

Summary of Companies' Response: The Companies disagree that they misuse policy language relating to pre-existing conditions. The Companies contend that under the policy, a Pre-existing Condition exists if a claimant has received medical treatment, consultation, care or services within a specified contractual period prior to the policy effective date. The Companies based any determinations of pre-existing conditions on whether their medical

resources find such a condition existed, and then whether the disability is "caused by, contributed by, or resulting from" the pre-existing condition (this is the most common policy language).

Since 2001, the Companies' claims handling procedures require that any determination by a claims-handler that a claim is non-compensable based on a pre-existing condition must first be approved by his or her manager. Under the new claims protocols, the determinations are also approved by one of the Companies' Quality Compliance Consultants**.** The phrase "contributed by" will also be deleted from the policy language.

(5) "Reservation of Rights"

The examiners reviewed three claims involving the concept of a "Reservation of Rights". In one case, the Companies misused the "Reservation of Rights" concept after coverage had been confirmed and payments made for up to six years. Upon determining that the claimant was not disabled, the Companies indicated to the claimant that the Companies have the right to request a refund of all previously paid benefits.

In three of the claim files the claimants indicated periods of hospitalization. However, the periods of hospitalization were not investigated prior to the Companies discontinuance of disability benefits.
The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of Companies' Response: The Companies disagree that reservation of rights is misused or that it is used in violation of CIC §790.03(h)(5). The Companies seek repayment of benefits paid under reservation of rights only in cases of fraud, misrepresentation, or where the delay in determining non-compensability is due to the claimant's lack of cooperation. The Companies' have implemented a number of initiatives to improve the handling of claims paid under a reservation of rights, including the following:

a. Inclusion of a notice of the fact that payment is being made under reservation of rights with each payment to ensure that the claimant is aware that they are being paid under reservation of rights.

b. The Companies have created clearer communications to claimants including an explanation of what the reservation of rights is and statements indicating that the Companies will not require repayment of payments made under reservation of rights unless claimant unreasonably fails to cooperate with appropriate information requests, (i.e., tax information, office records) commits fraud or misrepresents information.

c. The Companies will articulate in its letters to claimants the reasons why a reservation of rights exists, and what information is missing in order to make a final determination on the claim.

d. Claims that are on reservation of rights for longer than 90 days are reviewed by claims management in order to ensure that the reservation of rights is appropriate.

2. <u>The Companies misrepresented pertinent facts or insurance policy provisions relating to coverage at issue.</u> In 10 instances, the Companies misrepresented pertinent facts or insurance policy provisions relating to coverage at issue. Documents were reviewed during the examination indicating that the Company was aware that claims believed to be covered under ERISA (Employee Retirement Income Security Act) may not be subject to "bad faith" claims in excess of the actual benefits provided in the policy. Thus the Companies are aware that it is important to provide accurate information to claimants regarding the status of their claim as either ERISA or non-ERISA as their potential right to recovery may have been significantly different in a disputed claim. Eight claims were identified wherein the Companies included multiple references to ERISA in denial letters of non-ERISA claims. This may lead to confusion on the part of the claimant or their representative regarding their right to recovery on a disputed claim. Some of the denials indicated "It appears your policy coverage is governed by the Employee Retirement Income Security Act (ERISA)". Other denials did not actually state the claim was subject to ERISA but referenced ERISA three times in the explanation of the appeal process in place at the time. These citations included both Individual and Group long term disability policies not subject to ERISA. The Department alleges these acts are in violation of CIC §790.03(h)(1).

<u>Summary of Companies' Response</u>: The Companies did not misrepresent pertinent facts or insurance policy provisions relating to coverages at issue. The Companies sent letters to claimants that referred to ERISA timelines and the potential applicability of ERISA in an attempt to communicate that the Companies apply ERISA timelines and appeal provisions to their claim handling.

In 2003, the Companies changed the text of the letters they send to claimants. Those letters now refer to appeal rights and timelines without reference to ERISA.

3. <u>The Companies failed to properly document claim files.</u> In nine instances, the Companies files failed to contain all documents, notes and work papers**.** Three of the files were missing documents vital to the Companies decision to deny additional benefits on long term disability claims. The Department alleges these acts are in violation of CCR § 2695.3(a).

<u>Summary of Companies' Response:</u> The Companies have comprehensive guidelines relating to the documentation of claim files, and assert that these guidelines are in full compliance with applicable law and regulation, including CCR§2695.3(a).

In 2003, the Companies enhanced the documentation of roundtable reviews to include identification of the participants and the decision reached in these meetings. In 2004, the internal requirements were further augmented to include documentation of the rationale for the decisions reached in a roundtable setting.

Additionally in 2003, the Companies developed and implemented enhanced documentation guidelines for calculations of offers, negotiations and outcomes for commutations and settlements.